DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 09G163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 D C HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 248 WALNUT STREET, NW SU AMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) WASHINGTON, DC 20011 (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX TAG (X5) COMPLETION DATE W 000 DEFICIENCY) INITIAL COMMENTS W 000 An recertification survey was conducted from June 22, 2010, through June 23, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six males with various levels of mental retardation and disabilities. The finding; of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of Hecewed 81 clinical and administrative records including incident reports. GOVERNMENT OF THE DISTRICT OF COLUMBIA W 120 483.410(d)(3) SERVICES PROVIDED WITH DEPARTMENT OF HEALTH OUTSIDE SOURCES W 120 HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR The facility must assure that outside services WASHINGTON, D.C. 20002 meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure outside services met the clients needs, of one client included in the sample. (Client #1) The findings natude: I. On June 2:2, 2010, beginning at 12:05 p.m., Client #1 was observed at his day program. At QMRP visited the day program and an In-service 07-15-10 12:28 p.m., if e day program staff assisted the with the staff of the Day Program regarding client to sit down. A step stool was positioned feet elevation protocol, was done on slightly under the client's chair. July 15, 2010. QMRP and House Manager will make monthly visit to ensure proper implementation Interview with the day program Registered Nurse of the program. An updated copy of the protocol wa (RN) and the day program staff on June 22, 2010, at 1:10 p.m., revealed Client #1 has an order to also provided to the day program at the time elevate his ferit during the day. After the interview (See Attachment A1) Client #1 was observed with his feet elevated on BORATORY DIRECTOR'S OR I ROVIDERS PLEER REPRESENTATIVES SIGNATURE

ry deficiency statement ending with an asteriek (*) denotes a deficiency which the statitution may be excused from correcting providing it is determined that it delicately elementary which is present (/ vertices a centremy which the matterior may be excused from contacting providing it is determined that let safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated shows are disclosable 90 days. Owing the date of survey whe her or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 owing the date these do suments are made available to the facility. If deficiencies are cited, an approved plan of correction are encosause to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED OMB NO. 0938-0391 IDENTIFICATION NUMBER: (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 09G163 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 06/23/2010 D C HEALTH CARE 248 WALNUT STREET, NW SU MMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) WASHINGTON, DC 20011 (X4) ID PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG (XS) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE W 120 Continued From page 1 DEFICIENCY) the step stool. W 120 On June 23, 2010, at 10:23 a.m., review of Client #1's physician order dated, June 1, 2010, revealed an order for the client to "keep legs elevated when seated during the day." The facility failed to ensure that day program staff encouraged Client #1 to elevate his feet as prescribed. 2. Interview with the day program RN on June 22, A current ISP was provided to the day program 2010, at 12:40 p.m., revealed the day program 2. 07-15-2010 did not have a current individual support plan on July 15, 2010, QMRP will ensure that all the (ISP). Further interview revealed that the RN required documents at the day program are up to made several attempts to retrieve the client's ISP. date and available during monthly visits. An Record review on the same day at 12:47 p.m., In-Service training was completed with QMRP revealed the RN sent three notes to the Qualified by Program Manager on 06-28-10 Mental Reta dation Professional (QMRP) 06-28-2010 Program Manager will monitor for compliance requesting the client's current ISP. Further review on regular basis through calls and visits. revealed an ISP dated July 17, 2008, in an interview with the QMRP on June 23, 2010, at (See Attachment "A2" and H) approximate y 2:30 p.m., she acknowledged that the day program did not have a current ISP. W 130 483.420(a)(7) PROTECTION OF CLIENTS W 130 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.

The finding includes:

(Client #6)

This STAND/RD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients residing in the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 09G163 NAME OF PROVIDER OF SUPPLIER B. WING 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW Washington, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (24) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGUL TORY OR LSC (DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XB) COMPLETION TAG DATE W 130 Continued From page 2 DEFICIENCY W 130 An In-Service training was done on 08-03-10 for On June 22, 2010, at 7:38 a.m., Client #6 was 08-03-10 all direct care staff on privacy issues with the observed sitting on the toilet with the door wide individuals. QMRP/ House Manager will continue open while the direct care staff was assisting to monitor on daily basis and also to continue with other clients with their breakfast. At 7:45 a.m., quarterly training and retraining of all the staff, the qualified mental retardation professional (QMRP) wilked by and closes the door. When (Sec Attachment "B") interviewed at approximately 10:30 a.m., the QMRP ack nowledged that Client #6 was not provided privacy while using the bathroom. There was no evidence that staff ensured privacy during Ciler t #6's personal care. W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS W 153 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of the client's records, the lacility failed to ensure that all injuries of unknown crigin were consistently reported immediately to the administrator and to the State agency, for one of the thee clients included in the sample. (Cllants #1) The finding includes:

program with a bruise on his forehead,
PRM CMS-2567(02-99) Previous V asions Obsoleta Ev

Review of Client #1's day program nursing note dated January 11, 2010, on June 22, 2010, at approximately 1:15 p.m., revealed that Client #1 was observed as soon as he entered his day

Event ID: WUNG11

Facility (D; 09G163

If continuation sheet Page 3 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 09G163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW SUMMARY STATEMENT OF DEFICIENCIES (EACH)EPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX WASHINGTON, DC 20011 TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE IXEI COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG W 153 Continued From page 3 DEFICIENCY Interview with the day program registered nurse W 153 An In-service training was done with QMRP and (RN) on the same day at 1:18 p.m., revealed that 6-28-10 House Manager by the Program Manager / the qualified mental retardation professional Incident Management Coordinator on 06-28-10 (QMRP) was informed. regarding policy and procedure of reporting and following incidents. QMRP will make sure to Interview with the QMRP on June 23, 2010, at approximately 3:00 p.m., confirmed the day report all incidents to Incident Management Coordinator at the time of the incident to ensure program made her aware of the client's bruise. Further interview revealed there was no incident that all incidents as per protocol has been reported report completed for the bruise on Client #1's and investigated. Incident management coordinator forehead. will monitor the facility on quarterly basis for compliance. There was no evidence the facility reported the (See Attachment "C") injury of unknown origin to the administrator or to the Department of Health. W 194 483,430(e)(4) STAFF TRAINING PROGRAM W 194 Staff must be able to demonstrate the skills and techniques recessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to demonstrate competency in implementing clients eating precautions protocol, for one of the three clients included in the sample. (Client #2) The finding includes: During meal closervation on June 22, 2010, at 7:40 p.m., Clkint #2 was observed eating dinner, An In-service training was done on 08/03/10 with 08-03-10 using his fingers. The client held a fork in his all staff regarding cating protocols. All protocols right hand and used his fingers to pick up the rice, were reviewed and discussed. QMRP/House proceed and niezt. While the client was eating Manager will ensure proper implementation of the the rice portion, the staff asked the client to use

protocols by monitoring /observing and filling a

meal time observation sheet and reviewing the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/GLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (XS) DATE SURVEY A. BUILDING COMPLETED 09G163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SU MMARY STATEMENT OF DEFICIENCIES (EACH REFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (JUS) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE W 194 DEFICIENCY Continued From page 4 broccoli ar d meat with his fingers, there was no W 194 three conservative months. staff intervention. After the client completed his See Attachment "D1" and "D2". food, he scraped the plate with his fingers and began to flick his fingers clean. By the time, the program di ector assistance intervened, the plate was cleaned. After staff intervention, the client was observed taking his plate to the kitchen sink and sitting on the sofa. The client was observed bringing for d up and chewing on the food (numinating his food). The direct care staff attempted to get the client to drink a cup of water. Interview with the direct care staff on June 22. 2010, at 7:55 p.m., revealed that the client ruminates his food. Review of the Client #2's eating precaution protocol datud February 9, 2009, on June 23, 2010, at 11:10 a.m., revealed the following guidalines: provide verbal prompting to put your spoon down to help reduce his rate of eating and decrease the amount of food that the client puts in his mouth: - alternating solids with sips of a beverage is a good way to clear his mouth; however he usually prefers to drink after his meal; - encourage him to use a napkin to wipe his mouth after mouthful; and - add some juice to his water so the client will consume after his meal. Interview with the qualified mental retardation professional and assistant program director on June 23, 2010, at approximately 11:00 a.m.,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G183 B, WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SU MARY STATEMENT OF DEFICIENCIES (EACH)EFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PRÉFIX PROMDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG W 194 DEFICIENCY) Continued From page 5 confirmed that the facility failed to implement W 194 Client #2's eating protocol. W 249 483.440(d)(1) PROGRAM IMPLEMENTATION W 249 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives klentified in the individual program bian. This STANCARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure continuous active treatment, for one of the three clients in the sample. (Cliunt #2) The finding includes: The facility staff failed to implement Client #2's communication Individual Program Plan (IPP). An In-Service training was done with all direct 08-03-10 care staff on 08-03-10 regarding program Observations on June 22, 2010, at 5:00 p.m., implementation. QMRP/House Manager will staff was observed holding two items (box of monitor the above and also will retrain staff on popsicle sticks and a lighted wheel) in front of quarterly or as needed basis to ensure proper Client #2 and asking, "which one would you like". implementation of program as outlined. Program Client #2 was observed taking the box of popsicle sticks and pulling them under the sofa. Several Manager will check program implementation minutes later, the direct care staff was observed during routine visits. retrieving the box from under the sofa and asking

walking around the facility.

the client again, "which one would you like". The client was observed pushing the items away and

interview with the direct staff indicated that the

(See Attachment E)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 09@163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SU MMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG W 249 DEFICIENCY) Continued From page 6 client likes to play with the popsicle sticks and he W 249 will usually selects them. Review of Client #2's IPP dated August 21, 2009, on June 23, 2010, at approximately 1:00 p.m., revealed a program objective which stated, "[the client] will use a picture exchange system to express a reed, want, or desire with 25% independer ce within one year. Further review of the task analysis sheet indicated that the should implement the program as follows: - staff will give him a picture of the client using the popsicle sticks or a buzzer. If the client does not accept the ricture, staff should place the picture in his hands - staff will prompt him to look at picture; - staff will say the phrase, "[the client] has the sticks or buzzer; -[the client] will hand the picture back to the staff. If [the client] does not give the picture back, staff should provide hand over hand assistance; - staff will give him the object in the picture; and - staff will document the client's performance. Interview with the qualified mental retardation professional (QMRP)on June 23, 2010, at approximately 1:10 p.m., confirmed that the staff did not use ary pictures as the program instructs. There was no evidence that the staff implemented Client #2's communication goal. W 252 483.440(e)(1) PROGRAM DOCUMENTATION W 252 Data relative to accomplishment of the criteria

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	objectives of	nust be a	dividual program plan documented in measurable				i		
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1		ac chell	is in the sample. (Client #3)			j			
.	The finding r	iciudes:							
11	On June 22. 2	2010 at 2	4:40 p.m., Client #3 was	1		1			
1	bserved drin	king fron	a cup sitting on the living	ĺ	An In-service training was done with	all direct care	08-03-10 i		
	oom table. T Ostop sod	he direct	care staff asked the client	ſ	staff on 08-03-10 by the Psychologist	regarding			
	and.	removed	the cup from the client's	{	proper intervention and documentation	n of Behavior			
- !				J:	Support Plan, QMRP and House Man	RACT WITH	ł		
	terview with	the direc	t care staff on June 22,	1,	monitor the above on daily basis. Al	-Bot Mill	i		
					House Manager will	O QMKP/	[
	enavior suppli f food steali K		BSP) to address behaviors		House Manager will retrain staff on q	larterly to	ł		
1		•	· ·		ensure proper implementation of prog	ram. Program	1		
R	ecord venifica	tion on J	une 23, 2010, at 9:10		Manager will check program impleme	ntation during			
				ļ	outine visits,	1	- 1		
fo	od stealing	aven silli	laladaptive behavior of	jo	See Attachment F)]	- 1		
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i a r	n. Nevesied to	et the All	on Juna 23, 2010, at 9:40				-		
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Inte	rview with th	e qualifie	d mental retardation	i		!	}		
			nat the staff failed to dent of food stealing.	ļ			ſ		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIE NCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 DENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED D9G163 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SU WMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD RE CROSS-REFERENCED TO THE APPROPRIATE REGULI TORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX COMPLETION TAG DATE Continued From page 8 DEFICIENCY) W 252 There was no evidence that data had been W 252 collected in accordance with the client's BSP, which was necessary for a functional assessment of the client's progress. W 262 483.440(f)(3)(i) PROGRAM MONITORING & W 262 CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the oplinkin of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility falled to ensure that restrictive measures had been at proved by the Human Rights Committee (HRC), for one of three clients in the sample. (Clent#2) The finding includes: Minutes taken at meetings of the facility's HRC for the period June 2009 through June 8, 2010, were reviewed on June 23, 2010, beginning at 12:25 p.m. Review of Client #2's medical chart on June 22, 2010, beginning at 9;45 a.m., revealed the following orders for sedation: - Afivan 3 mg prior to an ENT appointment scheduled for June 7, 2010;

- Ativan 3 mg prior to a dental appointment

Ativan 3 mg prior to an audiology appointment.

scheduled on June 2, 2010; and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	on June 23, 2010, at	3:00 p.m., revealed that	ĺ	include the discussion and approved	of clians	7-8-10
j	DON-COmpliance has	e sedations to address his	}	# 2's sedations as it was reviewed at	the mostino	!
ļ	appointments Furth	viors prior to the medical		four not included by mistake in the F	TRC ourses	
ĺ	director at 4:00 p.m.	as interview with the program	1	by QMRP. In-Service and review of	the HRC	
!	discussed the cliente	" Micaled Inat the HRC	ļ	minutes with QMRP by Program Ma	nager was	
				conducted on 07/08/10 to include all	information on	
			1	schatten and medical appts for review	by HRC	
	483.460(c):3)(iii) NUR	ISING SERVICES	W 336	Program Manager will review minute filing HRC minutes to ensure that all	s prior to	
ļ,	Nursina salvicae muo	h Smatouri	77 300	information are included in the minute	uiscussed	
je	certified as not needin	g a medical care plan, a		(See Attachment G1 and G2)	es.	
1	review of their health s	g a medical care plan, a status which must be on a		1		
	quanterly or more frequ client need.	uent basis depending on			•	•
i	ment need.	· · · · · · · · · · · · · · · · · · ·			1	
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]]	This STANE ARD is no	ot met as evidenced by:	:		ļ	
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		ion of quarterly reviews, in the sample. (Client #1)	ļ		1	j
		" und sample. (Client #1)	[}	- 1
וד ן	he finding includes:	İ	j			ľ
Re	EVIOW of Client#4's	edical record on June 23,	i		ļ	}
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as	sessment lated June	25, 2009. Further review	}	Nursing quarterly in question was retried the main office at the state of the	ved from 0	5-23-10
			-	the main office at the time of the survey placed in the book. This was an oversig	and was	&
			į	QMRP. An In-service training was don	ntoy 0°	7-21-10
Me	ntal Retardation Draw	erview with the Qualified	ļ	Program Manager on 07-21-10 on "Reco	is by the]
23,	2010, at approximate	ssional (QMRP) on June		keeping and filing of documents" QMR1	P will	- 1
				check the books on quarterly basis to ma	ike sure alli	1
1	Treed Paris A fill alber	/ 3 PARRIE - 1	- 1	information are filed and are current. Pro	eram !	1
703	3.470(g)(2) SPACE AN	ID EQUIPMENT	14420	Manager will do audit of books on quarte	erly basis	
		l l	** 100	(Sec Attachment "H")		ſ
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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ļ	and teach clients to use choices at out the use hearing and other colland other textoss ideas.	use and to make informed e of dentures, eyeglasses,	W 436			
r c fe	ecord review, the facilitients additions drinking	ot met as evidenced by: s, staff interview, and lity's nurse failed to use ag cup as recommended, ants included in the sample.				
1, p. p. p. dii us me	. Meal observations on .m., Client:#1 was observations the meal he was ppy cup with handles. nner observations, Client a sippy cup with hedication observation is observed consumer.	andles. During the at 6:35 p.m., Client #1 g his medication with		An In-service training was conducted with on use of adaptive equipment on 07-06-16 Nursing staff is using adaptive equipment individuals (e.g. sippy cups, special spoor other needful devines) QMRP and House Manager will monitor to above or daily basis. Also registered nurse Program Manager will check unannounced implementation of above.	O. for hs or and	
inte adr the drin adm	erview with LPN, after ministration, indicated same typn of cup and lking cups during the ninistration.	the medication that all the clients used I no one used adaptive medication		See Attachment I)		
1:30	D.M. it was recome	Idividual Support Plan on June 23, 2010, at anded and confirmed urne all his liquids from	.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 (X4) ID SUI MARY STATEMENT OF DEFICIENCIES (EACH LIEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID PROVIDER'S PLAN OF CORRECTION REGULA FORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DATE W 436 DEFICIENCY Continued From page 11 W 436 a sippy cur. 2. During rheal observations on June 22, 2010, at 8:30 a.m., and 4:15 p.m., Client #3 was observed drinking his beverage using a sippy cup with handles. During the medication observation at 7:00 p.m., Client #3 was observed consuming his medication with water provided in a styrofoam cup. As the client consumed the water, the liquid was observed running out of his mouth, down his chin and on o his shirt. Further observations revealed the client coughing after he consumed the liquids. At 7:40 p.m. during dinner observations, Client #3 was observed drinkin his beverage using a sippy cup with handles. Interview with LPN, after the medication administration, indicated that all the clients use the same type of cup and no one used adaptive feeding cups during the medication administration. Review of Client #3's medical record indicated a diagnosis of oral dysphagia. Further review of Client #'3's feeding protocol dated March 10, 2010, on Jun. 23, 2010, at approximately 9:50 a.m., recommended the following feeding adaptive equipment: slppy cup, sectional plate, plate riser, etc.... According to the Individual Support Plan (ISP) dated March 16, 2010, on June 23, 201(), at 11:30 a.m., confirmed the following adaptive equipment: sippy cup with handles, weig ited teaspoon, divided plate, plate riser and slip resistant mat under plate.

Interview with the QMRP and program director on June 23, 2010, at approximately 4:00 p.m.,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G163 NAME OF PROVIDER OR SUPPLIER <u>06/23/2010</u> STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SU MMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH XEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (X5) COMPLETION TAG DATE DEFICIENCY) W 438 Continued From page 12 the adaptive sippy cup during medication W 436 administration, as well. At the time of the survey, the facility's nurse failed to ensure clients untilized recommended adaptive equipment during medication administration, W 440 483.470(i)(1) EVACUATION DRILLS W 440 The facility must hold evacuation drills at least quarterly to each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one of the seven shifts of duty reviewed. The finding includes: Interview with the Qualified Mental Retardation An In-service was conducted with all staff on Professional (QMRP) and review of the staffing 07-29-10 7-29-10, for quarterly fire drills per shift as per pattern on June 22, 2010, at 10:20 a.m. revealed the following staffing pattern: D.C.H.C policy, House Manager and QMRP will review fire drill reports monthly to ensure drills are Sunday - Saturday conducted on each shift as required. Program 6:30 a.m. - 2 30 p.m.; Manager will review fire drill log on quarterly basis 2:30 p.m.-10:30 p.m.; (See Attachment "D]") 10;30 p.m. - (3:30 a.m.; Monday-Friday 6:30 a.m. -10 30 a.m.; 10:30 a.m. - 2:30 p.m.; 2:30 p.m. to 10:30 p.m. and 10:30 p.m. to 5:30 a.m.

Review of the fire drill log revealed that the weekend shift for 6:30 a.m.-2:30 p.m., from June

AND DI AL	NT OF DEFICIE IC	l€s	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUA			- UN	D: 07/27/2
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¥ 455	483.470(1)(1)	INFECT	TION CONTROL	IAL 455			ļ
				¥¥ 455	An in-service training was conducted	with all staff	08-03-10
			ive program for the	ļ	on opening and injection control and	TIMit/orgol	
	and communic	able di	seases	1	precautions for hand-washing, OMR	Pand House	
]		•	 -	[Manager to observe for implementati	on of above.	
-	This STANGUA	3D -		1	QMRP will conduct quarterly In-Serv staff on proper infection control and v	ice with all	
	gased on pliss	rvati~~	of met as evidenced by: staff interview and record	,	to monitor at different times.	viii continue	
1	eview, the taci	lity faile	A to coord		(See Attachment D1 and D3)	ĺ	
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8:5	3.M., corfirm	会付 the	2 on June 22, 2010, at she did not assist Client			1	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED A BUILDING 09G163 B. WING NAME OF PROVIDER OR SUPPLIER 06/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 248 WALNUT STREET, NW SUMMARY STATEMENT OF DEFICIENCIES
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If continuation sheet Page 15 of 15

STATEMENT OF DEFICE NCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		FORM APPRO	
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000 1	INITIAL COMMENT	'S		1000	DEFICIENCY)		
1	SULVEY PIDIXOSS A	Jivey were based on	the full sec of six ation				
1 109	incident reports. 3504.16 HCUSEKEE Each GHMF:P shall latem of clothing as be	PING bel inconspicuously e	g each	i 109	An In-Service training was conducted or by Program Manager to QMRP and Hor	n 6-28-10	06-28-10
T B H fs in re	resident as indicated in tabilitation Plan (IHP) This Statute is not meleased on observation forme for Mentally Retailed to ensure that cluconspicuously, for one siding in the facility. The finding in cludes:	at as evidenced by: and interview, the Granded Persons (GHN othing items were late of the six residents (Resident #5)	oup IRP) peled		on how to label clothes properly with permarker in such away that individuals disprivacy are protected. QMRP will check clothes on weekly basis to ensure that the weather appropriate and in good repair, circulate unwanted clothing and maintain clothing in their drawers for use. (See Attachment "J")	manent mity and individuals ey are Also will	
Respondence of the control of the co	eserved wearing a paissident #5's initials we the tube socks in largith the direct care staffsident's initial's were acks. During the exit of 10, at 4:45 p.m., the cardation professional	or long white tube some written across the geblack letters. Interfections of the front of confirmed that the written on the front of confirme confirmed that the confirmed that the confirmed mantal tune 2	front view his				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT ON		NCIES On	(X1) PROVIDERSUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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1 135	3505.5 FIR				1 135			
	Column to 168	. ле епа	conduct simulated fire ctiveness of the plan for each shift.	e drills in at least				
	failed to hok for six of the	is weivis bucen xis hieen xis	net as evidenced by: nd record review, the tion drills at least qua- tents residing in the fa- tents residing in the fa-	ا مدسسه				
7	The finding i	ncludes:					i	
	COLESSIONS	(QMRP) ne 22 - 26	alified Mental Retards and review of the sta 010, at 10:20 a.m, re pattern:					
6	Sunday - Sat :30 a.m 2; :30 p.m10;	30 p.m.; 30 p.m.;						
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Health Regulation Administration PRINTED: 07/27/2010 STATEMENT OF DEFICIENCIES FORM APPROVED AND PLAN OF CORRECT ON (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING HFD03-0188 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/23/2010 D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH LIEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE AGTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG COMPLETE DEFICIENCY) 1 229 3510.5(f) STAFF TRAINING 1229 Each training program shall include, but not be limited to, the following: An In-service was conducted with all stuff on 7-29-10 7-29-10, for quarterly fire drills per shift as per (f) Specialty areas related to the GHMRP and the D.C.H.C policy, House Manager and QMRP will residents to be served including, but not limited review fire drill reports monthly to ensure drills are to, behavior management, sexuality, nutrition, conducted on each shift is required. Program recreation, total communications, and assistive Manager will review fire drill on quarterly basis technologies; (See Attachment D1) This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing residents' mealtime protocol, for two of the three residents in the sample. (Residents #1, #2 and #31 The findings include: 1. During mual observation on June 22, 2010, at 7:40 p.m., Resident #2 was observed eating An in-service training was done on 08/03/10 with dinner, using his fingers. The resident held a fork 08-03-10 all staff regarding eating protocols. All protocols in his right hand and used his fingers to pick up were reviewed and discussed. QMRP/House the rice, brockell and meat. While the resident Manager will ensure proper implementation of the was eating the rice portion, the staff asked the resident to use his utensils, to no avail. As the protocols by monitoring /observing and filling a resident ate the broccoli and meat with his meal time observation sheet and reviewing the fingers, there was no staff intervention. After the data with Program Manager on monthly basis for resident completed his food, he scraped the plate three consecutive months. with his fingers and began to lick his fingers clean. By the time, the program director (See Attachment D1 and D2) intervened, this plate was cleaned. After staff intervention, F esident #2 was observed taking his plate to the kitchen sink and sitting on the sofa. The resident vias observed bringing food up and chewing on the food (ruminating his food). The direct care stalf attempted to get the resident to drink a cup of water, eith Regulation Administration ATE FORM

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Health Regulation Administration PRINTED: 07/27/2010 STATEMENT OF DEFICE NCIES FORM APPROVED AND PLAN OF CORRECT ON (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED HFD03-0188 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/23/2010 D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SUI IMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH HEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S FLAN OF CORRECTION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETE TAG | 229 | Continued From page 3 DATE DEFICIENCY 1229 Interview with the direct care staff on June 22, 2010, at 7:56 p.m., revealed that the resident ruminates his food, Review of the Resident #2's eating precaution dated February 9, 2009, on June 23, 2010, at 11:30 a.m., revealed the following guidelines: - provide verbal prompting to put your spoon down to help reduce his rate of eating and decrease the amount of food that the resident Duts in his mouth: - alternating solids with sips of a beverage is a good way to clear his mouth, however he usually prefers to drink after his meal; - encourage him to use a napkin to wipe his mouth after (nouthful; and - add some juice to his water so the resident will consume after his meal. interview with the qualified mental retardation professional and assistant program director on June 23, 2010, at approximately 11:00 a.m., confirmed that the facility failed to implement Resident #2's eating protocol. 2. Meal observations on June 22, 2010, at 4:15 2&3 An In-service training was conducted with nurse p.m., Resident #1 was observed having a snack. 7-6-10 on use of adaptive equipment on 07-06-10. During the mual he was observed drinking from a Nursing staff is using adaptive equipment for sippy cup with handles. At 5:05 p.m., during individuals (e.g. - sippy cups, special spoons or dinner observations, Resident #1 was observed using a sippy cup with handles. During the other needful devices) medication observation at 8:35 p.m., Resident #1 QMRP and House Manager will monitor the was observed consuming his medication with above or daily basis. Also registered nurse and water provided in a styrofoam cup. As the Program Manager will check unannounced for Resident consumed the water, the liquid was implementation of above. ealth Regulation Administratio (See Attachment I) ATE FORM

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Health Regulation Administration STATEMENT OF DEFICIENCIES FORM APPROVED AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED HFD03-0188 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05/23/2010 D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SUM MARY STATEMENT OF DEFICIENCIES (EACH CERICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULA 'ORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETE TAG 1229 Continued From page 5 CATE DEFICIENCY) 1229 2010, on June 23, 2010, at approximately 9:50 a.m., recommended the following feeding adaptive equipment: sippy cup, sectional plate, plate riser, etc.... According to the Individual Support Plan (ISP) dated March 16, 2010, on June 23, 2010, at 11:30 a.m., confirmed the following adaptive equipment: sippy cup with handles, weighted teaspoon, divided plate, plate riser and slip resistant mat under plate. Interview with the QMRP and program director on June 23, 2010, at approximately 4:00 p.m., confirmed that Residents #1 and #3, the should use the adaptive slppy cup during medication administration, as well. At the time of the survey, the facility's nurse falled to ensure residents untilized recommended adaptive equipment during medication administration. 3521.7(g) HABILITATION AND TRAINING 1437 1437 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, let er writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide habilitation and training, for one of the three

WLNO11

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Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIE VOIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED HFD03-0168 8. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/23/2010 D C HEALTH CARE 248 WALNUT STREET, NW WASHINGTON, DC 20011 SUM MARY STATEMENT OF DEFICIENCIES (X4) ID (EACH | EFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULA 'ORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETE DATE DEFICIENCY 1437 Continued From page 6 1437 residents is cluded in the sample. (Resident #2) The finding includes: The facility staff failed to implement Resident #2's communication Individual Program Plan (IPP). Observations on June 22, 2010, at 5:00 p.m., staff was of served holding two items (box of An In-Service training was done with all direct 8-3-10 popsicle sticks and a lighted wheel) in front of care staff on 08-03-10 regarding program Resident #2 and asking, "which one would you implementation. QMRP/House Manager will like". Resident #2 was observed taking the box monitor the above and also will retrain staff on of popsicle sticks and putting them under the quarterly or as needed basis to ensure proper sofa. Several minutes later, the direct care staff was observed retrieving the box from under the implementation of program as outlined. Program sofa and asking the resident again, "which one Manager will check program implementation would you like". The resident was observed during routine visits. pushing the tems away and walking around the (See Attachment E) facility. Interview with the direct staff indicated that the resident like to play with the popsicle sticks and he will usually select them. Review of Resident #2's IPP dated August 21, 2009, on June 23, 2010, at approximately 1:00 p.m., reveale 1 a program objective which stated, "[the client] will use a picture exchange system to express a need, want, or desire with 25% independency within one year. Further review of the task analysis sheet indicated that the should implement the program as follows: staff will give him a picture of the resident using the popsicle slicks or a buzzer. If the resident does not accept the picture, staff should place the picture in his hands; staff will prorapts him to look at picture; aith Regulation Administration ATE FORM

	Y OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO HFD03-0188	er/Clia MBER:	(X2) MULT: A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
iame of	PROVIDER OR LIUPPLIER	7.000		}			
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1437	Continued From page	ge 7		1437	PERMERCY)	<u>i </u>
j	- staff will say the ph sticks or buzzer;	rase, "[the resident]		1437			
! !	-[the reside 11] will ha staff. If [the client] d staff should provided						
	- staff will give him th	e object in the pictur	e; and			1	
!	- staff will document	the resident's perform	nance.	}			
	Interview with the quaprofessional on June 1:10 p.m., confirmed pictures as the progravidence that the staff#2's communication g	23, 2010, at approxi- that the staff did not im instructs. There v	mately use any				
1 500	3523.1 RESIDENTS	RIGHTS	1	500			
P	Each GHMR a resident hat the rights of resident motected in succordant hapter, and other app aws.	ents are observed and	1d				
re Ri ar Ci tha	his Statute is not me ased on observations eview, the the Group Fetarded Pensons (GH not protect residents' ritle 7, Chapter 13 of the filled D.C. Law 2-137, hapter 19) and other that govern the care an ental retardation, for cluded in the sample.	, Interviews and reco dome for the Mentali MRP) failed to obser ights in accordance to be D.C. Code (former D.C. Code, Title 6, District and federal land dirights of persons with	y Ve with rly		•		

		IDENTIFICATION NL	ER/CLIA IMBER:	(X2) MU A. BUILD	LTIPLE CONSTRUCTION	(XS) DATE :	URVEY
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AME OF PROVIDER OR IN	PPLER		STOCET .			no.	2100-
C HEALTH CARE			SINCEL A	PURESS, CIT	, STATE, ZIP CODE	00/2	3/2010
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1 500 Continued =	rom pag	je 8		1500	OEFICENCY)		
Minutes teles				Ì	HRC minutes dated 6-8-10 were ar		
for the positive	n ai me	etings of the facility's	HRC				07-08- 10
					include the discussion and approva	of client	
12;25 p.m A	ح متحاراها، آثار این ف	ne 23, 2010, beginni of Resident #2's med	ng at		# 2's sedations as it was reviewed a	t the meeting	
					but not included by mistake in the	HRC summary	
revealed the	ollowing	orders for sedation	a.m.,		by QMRP. In-Service and review of	of the HRC	
				į	minutes with QMRP by Program M	anager was	
j - Ativan 3 mg	prior to	an ENT appointmen	. 1		conducted on 07/08/10 to include a	informetion on !	
scheduled for	June 7.	, 2010;	'		sodation and medical appts for review	and manon on	
			- 1		Program Manager will review minu	w by nkC	
- Ativan 3 mg	Ativan 3 m prior to a dental appointment cheduled on June 2, 2010; and Ativan 3 mp prior to an audiology appointment.						
scheduled o 1					filing HRC minutes to ensure that a	ll discussed	
					information are included in the mini	ites.	
]	(Sec Attachment G1 and G2)		
on June 23, 20 Resident #2 te his non-compile appointments, director at 4:(10 discussed the	mrtry, 110, at 3 ceived t ance be Further p.m., in esident	lified mental retardat and further record retains and further record retains to additions to additions prior to the retainment of the retainment of the retainment of the HRI seedations, however that the HRC approximation of the HRC approximation of the HRC approximation of the HRC approximation of the HRC approximation of the HRC approximation of the HRC approximation of the HRC approximation of the HRI approximation	eview nat ress nedical rogram C				